State of California—Health and Human Services Agency
Department of Health Services

SANDRA SHEWRY
Director

ARNOLD SCHWARZENEGGER
Governor

April 19, 2006

Dear Interested Parties:

DISEASE MANAGEMENT PILOT PROGRAM REQUEST FOR PROPOSAL (RFP) 05-45889 ADMINISTRATIVE BULLETIN 4, ADDENDUM 4

Administrative Bulletin 4, Addendum 4 issued by the California Department of Health Services, Office of Medi-Cal Procurement (OMCP), announces several revisions, clarifications and corrections to the original RFP and release of the Bidder's Questions and Official Answers.

In order to configure the RFP so that it accurately reflects the current requirements and considerations, remove the existing page(s) in your copy of the RFP and insert the appropriate replacement page(s) as indicated in the following table:

Remove (existing pages)	**Replace** (new pages)
Table of Contents - Page 2	Table of Contents - Page 2
RFP Main Text - Pages 14, 31-33	RFP Main Text - Pages 14, 31-33
Exhibit A, Attachment I - Pages 1, 2, 12, 14 and 18 of 18	Exhibit A, Attachment 1 - Pages 1, 2, 12, 14 and 18 of 18
Exhibit B - Pages 2 and 3 of 3	Exhibit B - Pages 2 and 3 of 3
Exhibit B, Attachment I - Page 3 of 3	Exhibit B, Attachment I - Page 3 of 3
Appendix 1 (Glossary) - Page 1 of 6	Appendix 1 (Glossary) - Page 1 of 6

Within the text of the document, changes appear in underlined print with a vertical bar appearing to the left of the paragraph where changes were made.

If you should have further questions, please contact Beverly Fisher, lead analyst assigned to this procurement, at (916) 552-8006.

Sincerely,

Original signed by *Donna Martinez*

Donna Martinez, Chief
Office of Medi-Cal Procurement

Proposers transmitting a Letter of Intent by fax are responsible for confirming the receipt of the faxed Letter of Intent by the stated deadline.

Call Beverly Fisher at (916) 552-8006 to confirm faxed transmissions.

4. Proposer warning

a. CDHS' internal processing of U.S. mail may add 48 hours or more to the delivery time. If forms are mailed, consider using certified or registered mail and request a receipt upon delivery.

b. For hand deliveries, including special courier and messenger services, allow sufficient time to locate on street metered parking and to check in at the security station. Ask security personnel to call Beverly Fisher (or her designee) at (916) 552-8006 to arrange for pickup and receipt issuance by OMCP staff (if required).

c. Due to parking restrictions at this location, express delivery companies (Fed Ex, UPS, DHL, etc.) deliver to the building's loading dock area. CDHS internal processing of express deliveries may add 12-24 hours to the delivery time, and should be considered when determining your shipping date and time.

Note: See Appendix 6 for map and directions to OMCP.

I. Scope of Work

See Exhibit A entitled, "Scope of Work" and Exhibit A, Attachment I entitled, "Scope of Work - Contract Performance" that is included in the Sample Contract Forms and Exhibits section of this RFP. Exhibit A and Exhibit A, Attachment I contain a detailed description of the services and work to be performed as a result of this procurement.

J. Qualification Requirements

Failure to meet the following requirements by the proposal submission deadline will be grounds for CDHS to deem a Proposer nonresponsive. Evaluators may choose not to thoroughly review or score proposals that fail to meet these requirements. In submitting a proposal, each Proposer must certify and prove that it possesses the following qualification requirements:

1. At least two (2) years of experience developing, implementing and managing disease management or case management programs. All experience must have occurred within the past five (5) years.

2. The Proposer must have current disease management accreditation by one of the following nationally recognized accrediting agencies: Joint Commission on Accreditation of Healthcare Organizations (JCAHO), National Committee on Quality Assurance (NCQA), or Utilization Review Accreditation Commission (URAC). Accreditation must be maintained through the life of the contract.

3. Proposers must certify they have read and are willing to comply with all proposed terms and conditions addressed in the RFP section entitled, "Contract Terms and Conditions", including the terms appearing in the referenced contract exhibits.

4. Corporations must certify they are in good standing and qualified to conduct business in California.

5. Non-profit organizations must certify they are eligible to claim nonprofit status.

d. If a Proposer's claims on the Required Attachment / Certification Checklist cannot be proven or substantiated, the proposal will be deemed nonresponsive and rejected from further consideration.

2. Stage 2 – Technical Proposal evaluation/scoring

a. Proposals that appear to meet the basic format requirements, initial qualification requirements and contain the required documentation, as evidenced by passing the Stage 1 review, will be submitted to a rating committee.

The raters will individually and/or as a team review, evaluate and numerically score proposals based on the proposal's adequacy, thoroughness, and the degree to which it complies with the RFP requirements.

b. CDHS will use the following scoring system to assign points. Following this chart is a list of the considerations that raters may take into account when assigning individual points to a technical proposal.

Points	Interpretation	General basis for point assignment
0	**Inadequate**	Proposal response (i.e., content and/or explanation offered) is inadequate or does not meet CDHS' needs/requirements or expectations. The omission(s), flaw(s), or defect(s) are significant and unacceptable.
1	**Barely Adequate**	Proposal response (i.e., content and/or explanation offered) is barely adequate or barely meets CDHS' needs/requirements or expectations. The omission(s), flaw(s), or defect(s), may be consequential but are acceptable.
2	**Adequate**	Proposal response (i.e., content and/or explanation offered) is adequate or meets CDHS' needs/requirements or expectations. The omission(s), flaw(s), or defect(s), if any, are inconsequential and acceptable.
3	**More than Adequate**	Proposal response (i.e., content and/or explanation offered) is more than adequate or fully meets CDHS' needs/requirements or expectations.
4	**Excellent or Outstanding**	Proposal response (i.e., content and/or explanation offered) is well above average or exceeds CDHS' needs/requirements or expectations. Proposer offers one or more enhancing features, methods or approaches that will enable performance to exceed CDHS' basic expectations.

c. In assigning points for individual rating factors, raters may consider issues including, but not limited to, the extent to which a proposal response:

1) Is lacking information, lacking depth or breadth or lacking significant facts and/or details, and/or

2) Is fully developed, comprehensive and has few if any weaknesses, defects or deficiencies, and/or

3) Demonstrates that the Proposer understands CDHS' needs, the services sought, and/or the contractor's responsibilities, and/or

4) Illustrates the Proposer's capability to perform all services and meet all scope of work requirements, and/or

5) If implemented, will contribute to the achievement of CDHS' goals and objectives, and/or

6) Demonstrates the Proposer's capacity, capability and/or commitment to exceed regular service needs (i.e., enhanced features, approaches, or methods; creative or innovative business solutions).

d. Below are the point values and weight values for each rating category that will be scored.

1) The Technical Proposal will be scored on a scale of 0 to 328 points, as follows:

Rating Category	Points	X	Weight	=	Total
Executive Summary	20	X	1.3	=	26.0
Agency Capability	68	X	0.6	=	40.8
Work Plan	164	X	1.0	=	164.0
Management Plan	44	X	0.9	=	39.6
Project Personnel	12	X	3.2	=	38.4
Facilities and Resources	12	X	1.6	=	19.2
			Grand Total		**328.0**

3. Stage 3 – Scoring the Rate Proposal

a. The proposal offering the lowest total rate proposal earns 328 Rate Proposal points. The remaining proposals earn rate proposal points through the rate conversion formula shown below. Final calculations shall result in numbers rounded to two decimal places.

$$\frac{\text{Lowest Rate}}{\text{Another Proposal's Rate}} \times 328 \text{ (Possible rate points)} = \text{Rate Proposal score of the other}$$

b. **Example for illustration purposes only**:

Lowest rate proposal earns 328 points.

$78 (lowest rate) ÷ $100 (another proposal cost) = .78

.78 X 328 points = 255.84 (Rate Proposal Section Score of another Proposer)

4. Stage 4 – Combining Technical Proposal Score and Rate Proposal Score

CDHS will combine the Technical Proposal score to the final Rate Proposal Section score and will tentatively identify the firm with the highest combined proposal score from each of the earlier evaluation stage(s).

5. Stage 5 – Adjustments to Score Calculations for Bidding Preferences

a. CDHS will determine which firms, if any, are eligible to receive a bidding preference (i.e., small business or non-small business subcontractor preference.

b. To confirm the identity of the highest scored responsive Proposer, CDHS will adjust the total score for applicable claimed preference(s) for those Proposers eligible for bidding preferences. CDHS will apply preference adjustments to eligible Proposers according to State regulations following verification of eligibility with the appropriate office of the Department of General Services. More information about the allowable bidding preferences appears in the RFP section entitled, "Preference Programs".

6. Stage 6 – Final Score Calculation

CDHS will use the formula shown below to calculate final proposal scores and to determine the highest scored proposal.

a. Technical Proposal Score (0-328) x 70% = Technical Score
b. Rate Proposal Score (0-328) x 30% = Rate Score

c. Technical Score
\+ Rate Score
= Total Point Score

N. Technical Proposal Rating Factors

Raters will use the following criteria to score the technical portion of each proposal.

1. Executive Summary

Executive Summary Evaluation Questions Section K.3.c [Not to exceed 3 pages]	**Points Possible**	**Points Earned**
1.1 To what extent did the Proposer express, in its own words, its understanding of CDHS' needs and the importance of this project? **Assign 1 point or 0 points if the Proposer restates or paraphrases information in the RFP.**	**4**	
1.2 To what extent did the Proposer demonstrate the tangible results that it expects to achieve? **Assign 1 point or 0 points if the Proposer restates or paraphrases information in the RFP.**	**4**	
1.3 To what extent did the Proposer express a sincere commitment to perform this work in an efficient and timely manner?	**4**	
1.4 To what extent did the Proposer demonstrate that it can effectively integrate this project into its current obligations and existing workload?	**4**	
1.5 To what extent did the Proposer adequately explain why it should be chosen to undertake this project at this time?	**4**	
Executive Summary Score ____ **Points earned X 1.3 =** _____		

Exhibit A, Attachment I
Scope of Work - Contract Performance

A. Contract Administration

Contractor shall maintain the organizational and administrative capabilities to perform its duties and responsibilities under the Contract. This will include, at a minimum, the following:

1. Organization and Staffing

   Contractor shall maintain the organization and staffing for implementing and operating the Contract. Contractor shall ensure the following:

   a. Organization has an accountable governing body;

   b. Staffing in medical and other health services, and in fiscal and administrative services, is sufficient to result in the effective conduct of the organization's business; and

   c. Written procedures for the conduct of the business of the organization, which provides effective controls.

2. Medical Oversight

   a. Contractor shall ensure that medical decisions, including those by subcontractors, are not unduly influenced by fiscal and administrative management.

   b. Contractor shall maintain a physician as Medical Director who is licensed in California but is not required to be located in California and whose responsibilities shall include, but not be limited to, the following:

      1) Ensuring that medical decisions are rendered by qualified medical personnel;

      2) Ensuring that medical decisions are not influenced by fiscal or administrative management considerations;

      3) Ensuring that medical protocols and rules of conduct for medical personnel are followed;

      4) Resolving disputes related to the Member and provider services; and,

      5) Direct involvement in the implementation of Quality Improvement activities.

   c. Contractor shall report to CDHS any changes in the status of the Medical Director within ten (10) calendar days.

Exhibit A, Attachment I
Scope of Work - Contract Performance

3. Reporting Requirements

Many of the data elements required below may be combined into grouped reports of related elements. Additionally, the Contractor may use electronic spreadsheets to track and report necessary data elements. All reports provided to CDHS must be user friendly (easily viewable and printable) and not contain excessive amounts of unsolicited data. The Contractor will submit the following reports:

a. Monthly Reports

The Contractor shall send monthly reports to CDHS that include the following information. CDHS must receive these monthly reports by the tenth calendar day of each month.

1) Identification of potential Members, including but not limited to the listing provided by CDHS, and the method and date of initial contact with the potential Member;

2) Identification of Members enrolled in the DMPP, or the date the Potential Member opted-out;

3) Identification of Provider/Primary Care Provider (PCP) providing DM services to DM Members;

4) Identification of individual Member 60-day assessment due dates and completion dates;

5) Identification of individual Member 90-day Individual Treatment Plan (ITP) deadline date and ITP initiation date;

6) Identification of Members who have been disenrolled, disenrollment date and the reasons for disenrollment. (This report is intended to report disenrollments after they have occurred. All Contractor requests for disenrollment must be approved by CDHS through a separate process. See Member Services - Scope of Services - Enrollment/Disenrollment below);

7) Health advice line activity, including the number and type of calls; and

8) Other reports to be determined by CDHS.

b. Quarterly Reports

The Contractor shall send quarterly reports to CDHS that include the following information. CDHS must receive these quarterly reports within thirty (30) calendar days after the end of the quarter.

1) Provider training;

Exhibit A, Attachment I
Scope of Work - Contract Performance

2. Enrollment/Disenrollment

CDHS will supply the Contractor with a monthly list of potential Members. The contractor must make a good faith effort to contact all potential Members with information regarding the DMPP benefits, services and enrollment/disenrollment procedures. Once the list is exhausted, CDHS will supply additional lists as necessary. Contractor shall provide written notice of eligibility to potential Members within five (5) working days of receiving the list from CDHS. If a potential Member chooses not to be enrolled, they will have thirty (30) days to opt-out of the program from the postmark of the initial eligibility contact letter. At the beginning of the first month following the end of the 30-day opt-out period, the potential Members who have not opted-out will be enrolled as Members.

The Contractor shall enroll a minimum of 250 DMPP Members in each of the six disease categories in each county in each year of the operations period of the contract. The purpose of this requirement is to ensure that there is a statistically valid sample size to evaluate for each disease in each pilot county. There are no enrollment distribution mandates beyond this minimum enrollment requirement. The minimum enrollment requirements will be subject to availability of sufficient numbers of potential Members in the pilot areas and will be subject to CDHS approval which shall not be unreasonably withheld.

The size of the initial enrollment list and any additional time allowed for the initial enrollment is subject to CDHS approval which shall not be unreasonably withheld. In addition, enrollment may only take place during the Operations Period.

The DMPP will provide disease management services to those persons who meet all of the following requirements:

a. Are Medi-Cal eligible;
b. Are 22 years of age or older;
c. Have a primary or secondary diagnosis of:
    1. Artherosclerotic disease syndrome;
    2. Congestive heart failure (CHF);
    3. Coronary artery disease (CAD);
    4. Diabetes mellitus (Diabetes);
    5. Asthma; or
    6. Chronic obstructive pulmonary disease (COPD)

All Medi-Cal beneficiaries who meet the qualifications noted above will be considered eligible for the DMPP, except those who:

- Have restricted/emergency only Medi-Cal;
- Are Medicare eligible;
- Have other insurance that provides comparable DM services (e.g., Medi-Cal Managed Care);
- Reside in nursing facilities (NF);
- Reside in all levels of Intermediate Care Facilities for the Developmentally Disabled (ICF/DD);
- Have a Medi-Cal eligibility period that is less than 3 months;
- Have a Medi-Cal eligibility period that is only retroactive;
- Are eligible as medically needy;

Contractor shall notify CDHS within two (2) business days of the Member's request. Disenrollment will occur on the first day of the month following the month the request was made. Former Members who disenrolled voluntarily may reenroll at any time by making a verbal or written request to the Contractor. Reenrollment will take place on the first day of the month following the month the reenrollment request is made.

3. Disease/Case Management

The Contractor will adopt DM standards to improve the health of Members by providing services based on evidence-based practice guidelines to include: promoting collaborative relationships with providers, providing Member and provider education, and employing reporting and feedback loops for decision making with providers and Members.

The Contractor will ensure continuity of care in collaboration with the provider/PCP by:

a. Monitoring the referral and follow-up of Members in need of specialty care and routine health care services;
b. Documentation of referral and follow-up services in Member's record;
c. Documentation in Member's record of emergency medical encounters with the appropriate follow-up as medically indicated; and
d. Documentation and follow-up in Member's record of planned health care services.

Disease/case management activities should include, but are not limited to the following:

a. Medication management – The Contractor shall develop and implement policies and procedures for the following elements:

   1) Medication profiling;

   2) Medication monitoring;

   3) Feedback to provider/PCP and/or pharmacist; and

   4) Member and provider education.

b. ITP - Based on the Member assessment, the Contractor shall assure and coordinate the development of the ITP, utilizing evidence-based practice guidelines, to be completed and in place within ninety (90) days of membership. The Member or the Member's designee, the provider/PCP and Case Manager should be actively involved in the development and periodic review of the ITP.

   The ITP must also include specific provisions for periodic (not less than semi-annually) review and updates to the plan as appropriate. Intervals of periodic

c. Resource tools developed by the Contractor to facilitate the use of evidence-based practice guidelines by the provider/PCP.

d. Evaluation and appropriate treatment of mental health issues.

e. Identification and utilization of community resources.

2. Provider Feedback

Contractor shall develop and implement system(s), which will provide information to the provider/PCP relating to Member's adherence to the ITP. Contractor shall employ feedback techniques to the provider/PCP to improve the quality and appropriateness of the care provided to the Member.

J. IMPLEMENTATION PLAN AND DELIVERABLES

The Implementation Plan and Deliverables section describes CDHS requirements for specific deliverables, activities, and timeframes that the Contractor must complete during the Implementation Period before beginning operations.

Once the Contract is awarded, the Contractor has fifteen (15) calendar days after its signs the Contract to submit a Workplan for each county that describes in detail how and when the Contractor will submit and complete the deliverables for the readiness review to CDHS. The Contractor's Workplan(s) will include a timetable to accomplish the activities to assure timely start-up of operations and contingency plan(s) in the event of implementation delays.

The Contractor's workplan(s) will identify all of the deliverables, milestones, and timeframes to achieve an orderly sequence of events that will lead to compliance with all contract requirements. CDHS will review and approve each workplan(s). However, Contractor shall not delay the submission of deliverables required in the workplan(s) while waiting for CDHS approval of previously submitted deliverables required by the workplan(s). Contractor will continue to submit deliverables based on the milestones and timeframes set forth in the approved CDHS workplan(s). In the event the Contractor fails to submit all deliverables in accordance with the milestones and timeframes in the approved CDHS workplan(s), CDHS may impose Liquidated Damages in accordance with Exhibit E - Additional Provisions.

The Implementation Period begins with the effective date of the Contract and extends to the beginning of the Operations Period (approximately 4 months after the effective date of the Contract). The Operations Period is the period of time beginning with the effective date of the first month of operations and continues through the last month of the services to the Members.

Upon successful completion of the Implementation Plan and Deliverables section requirements, CDHS will authorize, in writing, that the Contractor may begin the Operation Period. Phaseout requirements are identified in Exhibit E-Additional Provisions.

Exhibit B
Budget Detail and Payment Provisions

4. Amounts Payable

A. The amounts payable under this agreement shall not exceed:

1) Up to $4,000,000 for the budget period of 08/01/06 through 11/30/07 (16 months).
2) Up to $4,000,000 for the budget period of 12/01/07 through 11/30/08 (12 months).
3) Up to $4,000,000 for the budget period of 12/01/08 through 02/28/10 (15 months).

The maximum amount payable under this Contract shall be up to $12,000.000. Case Management Fee payments will only be paid for enrolled Members during the operations period.

B. Reimbursement shall be made for allowable expenses up to the amount annually encumbered commensurate with the state fiscal year in which services are performed and/or goods are received.

C. The Contractor must maintain records reflecting actual expenditures for each state fiscal year covered by the term of this agreement.

5. Timely Submission of Final Invoice

A. A final undisputed invoice shall be submitted for payment no more than ninety (90) calendar days following the expiration or termination date of this agreement, unless a later or alternate deadline is agreed to in writing by the program contract manager. Said invoice should be clearly marked "Final Invoice", thus indicating that all payment obligations of the State under this agreement have ceased and that no further payments are due or outstanding.

B. The State may, at its discretion, choose not to honor any delinquent final invoice if the Contractor fails to obtain prior written State approval of an alternate final invoice submission deadline. Written State approval shall be sought from the program contract manager prior to the expiration or termination date of this agreement.

C. The Contractor is hereby advised of its obligation to submit, with the final invoice, a "Contractor's Release" (Exhibit F) acknowledging submission of the final invoice to the State and certifying the approximate percentage amount, if any, of recycled products used in performance of this agreement.

6. Progress Payment Withholds

A. This provision replaces and supersedes provision 22 of Exhibit D(F).

B. Progress payments may not be made more frequently than monthly in arrears for work performed and costs incurred in the performance of the agreement. In the aggregate, progress payments may not exceed 90 percent of the total agreement amount, regardless of agreement length.

C. Ten percent (10%) may be withheld by CDHS from each invoice submitted for reimbursement, pending receipt of satisfactory completion of all reporting requirements for each operational year.

D. Release of Amounts Withheld

As all reporting requirements for the operational year are completed in their entirety by either the Contractor or Subcontractor any funds withheld for that period may be released to the Contractor upon acceptance and/or acknowledgement that all such items have been completed to the full satisfaction of CDHS.

E. Payment Requests Excluded from the 10 Percent (10%) Withhold

Ten percent (10%) payment withholds shall not be applied to reimbursements or periodic payment requests for direct costs associated with equipment purchases, media buys, operating expense items, and other procurements not directly associated with the Contractor's personal performance.

7. Expense Allowability / Fiscal Documentation

A. Invoices, received from a Contractor and accepted and/or submitted for payment by the State, shall not be deemed evidence of allowable agreement costs.

B. Contractor shall maintain for review and audit and supply to CDHS upon request, adequate documentation of all expenses claimed pursuant to this agreement to permit a determination of expense allowability.

C. If the allowability or appropriateness of an expense cannot be determined by the State because invoice detail, fiscal records, or backup documentation is nonexistent or inadequate according to generally accepted accounting principles or practices, all questionable costs may be disallowed and payment may be withheld by the State. Upon receipt of adequate documentation supporting a disallowed or questionable expense, reimbursement may resume for the amount substantiated and deemed allowable.

8. Special Payment Provisions

Refer to attached Exhibit B, Attachment I for *Special Payment Provisions* specific to this contract.

Exhibit B, Attachment I
Special Payment Provisions

7. Invoicing and Payment Additional Requirements

The Invoicing and Payment requirements stated in Exhibit B, *Budget Detail and Payment Provisions,* Provision 1, entitled *Invoicing and Payment*, paragraph C, are minimum standards and additional billing information may be required as the project develops. Any additional requirements will be considered normal business operation and not require a contract amendment.

8. Savings Guarantee and Calculation Methodology

a. The Disease Management Organization (DMO) shall guarantee California Department of Health Services a zero percent increase in net medical costs for Medi-Cal members who are eligible for the Disease Management Pilot Program (DMPP). Restated, the DMO guarantees that the program will create savings equivalent to the DMPP contracted DMO fees. One hundred percent of the DMO's fees will be at risk for this guarantee of cost-neutrality. If CDHS terminates the contract in the first 16 months, the Contractor will be held to no guarantee. If CDHS terminates the contract after 16 months but before 28 months, the cost-neutrality guarantee will be changed to a guarantee to limit the net increase of medical costs to five percent. If CDHS terminates the contract after 28 months but before 43 months, the cost-neutrality guarantee will be changed to a guarantee to limit the net increase of medical costs to two and one-half percent.

b. The DMO's guarantee shall be proportionate, in that, as needed, the DMO shall refund its fees in the same proportion that the cost-neutrality target is missed. However, the DMO will not be liable for more than 100% of its fee.

c. DMPP savings are calculated using the following formula: Per member per month (PMPM) costs of the matched control group – PMPM costs of DMPP eligibles x DMPP eligible months.

d. Costs for Medi-Cal fee-for-service (FFS) beneficiaries without DM services will be estimated using the average (mean) PMPM total Medi-Cal costs of a matched control group. The matched control group will be selected from Medi-Cal FFS beneficiaries from outside the pilot areas who meet the DMPP eligibility criteria. The matched control group's membership will be determined through a statistical matching method by a third-party evaluation contractor. Costs for DMPP eligibles in the pilot area and the matched control group will be determined by actual costs in the contract period after a six-month lag time for run-out claims. Per member costs of DMPP eligibles will include DMPP DMO fees paid (the fee is only paid for DMPP members, but for the guarantee calculation, the fee total will be added to the total medical costs of DMPP eligibles in the pilot areas and averaged).

e. The determination of costs for both the DMPP eligibles and the matched control group will follow the same algorithm. Cost comparisons shall be made on a PMPM basis, using the formula: *costs divided by member months*. Costs will be accumulated as total Medi-Cal expenditures during the operations period of the

Appendix 1

Glossary

As used in this Contract, unless otherwise expressly provided for, or the context otherwise requires, the following definitions of terms are specific to the construction of this Contract:

Accreditation: Accreditation is the process by which an impartial group provides recognition and certification to a group or organization that demonstrates and maintains the standards set by the accrediting organization.

Administrative Model: A federal set of rules that regulate funding for State Medicaid program services that are not direct medical services but are related to the administration and support of medical programs. This model does not require a State Plan Amendment or waiver(s) to implement.

Administrative Case Management Services: Services that include assistance in accessing a medical or other service, but does not include the direct delivery of the underlying service. Activities commonly understood to be allowable include: 1) assessment of the eligible individual to determine service needs, 2) development of a specific care plan, 3) referral and related activities to help the individual obtain needed services, and 4) monitoring and follow-up.

Appeal: A grievance process for resolving disputes.

Asthma: A condition often of allergic origin that is marked by continuous or paroxysmal labored breathing accompanied by wheezing, by a constriction of the chest, and often by attacks of coughing or gasping.

Atherosclerosis: a common arterial disorder characterized by yellowish plaques of cholesterol, lipids, and cellular debris in the inner layers of the walls of large and medium-sized arteries. The vessel walls become thick, fibrotic, and calcified, and the lumen narrows, resulting in reduced blood flow to organs normally supplied by the artery.

Atherosclerotic Disease Syndromes: a complex of signs and symptoms resulting from a common cause (Atherosclerosis) or appearing, in combination, to present a clinical picture of a disease or inherited abnormality. Examples include: ischemic heart disease, myocardial infarction, Angina pectoris, Atherosclerosis of the extremities.

Beneficiary: Any person certified as eligible for medical assistance under the Medi-Cal program.

Case Management: Any intervention undertaken with the purpose of helping a member receive appropriate care, whether post-acute or in lieu of acute care, where that Member has any disease(s) or condition(s). It is distinguished from utilization management in that it is voluntary.

Case Management Fee: An all inclusive monthly rate for DM services per enrolled DMPP member.

Disease Management Pilot Program RFP# 05-45889

Proposer's Questions and Official Answers

QUESTION #	RFP SECTION	Pg	QUESTIONS	ANSWERS
			Section: RFP Main	
1	RFP Main, Section J.1, Qualification Requirements	14	The qualifications state: 1. The Proposer must have current DM accreditation by one of the following nationally recognized accrediting agencies: (JCAHO), (NAQA), or Utilization Review Accreditation Commission (URAC). However, in attachment 2 the certification checklist question 2 which addresses this qualification requirement gives the option of answering "n/a". The question is whether of not disease management accreditation is truly required even if the Proposer is not otherwise bound to maintain accreditation by these agencies e.g. a community retail chain. Therefore, I am requesting clarification on this issue.	Accreditation is necessary to be considered eligible for the DM contract and accreditation status must be maintained. The requirement for accreditation shall be maintained and included in a future addendum.
2	RFP Main, Section J.1, Qualification Requirements	14	If the Subcontractor is a DMO with NCQA accreditation, will that meet the states's requirement or does the prime contractor need to have DM accreditation?	The prime contractor must have DM accreditation.
3	RFP Main, Section J.1, Qualification Requirements,	14	If the Subcontractor is a DMO with more that 5 years of experience, will that meet the states requirement or does the prime contractor need to have 5 years of DM experience?	No, the prime contractor must have at least two (2) years of experience developing, implementing and managing disease management or case management programs. All experience must have occurred within the past five (5) years.
4	RFP Main, Section K.2.b.3	17	This section requires printed pages be single-sided. Does this requirement also apply to appendices?	Yes
5	RFP Main, Sections K.3.e.3 and K.3.e.4 Work Plan	20	Section K.3.e.3 provides a list of items (a) through (h) to be addressed in the Work Plan (Attachment 11). Section K.3.e.4 identifies specific topics to be addressed in the proposal. Please clarify where items (a) through (h) should be located in the proposal?	A work plan must be submitted for each section listed in K.3.e.4 and contain the elements listed in K.3.e.3. The order of placement in the proposal of the workplans is listed in K.3, p.18

Disease Management Pilot Program RFP# 05-45889

Proposer's Questions and Official Answers

QUESTION #	RFP SECTION	Pg	QUESTIONS	ANSWERS
6	RFP Main, Section K.3.e.4, Work Plan	21	Also, identifies requirements to be addressed in the specific plans required by RFP. Please clarify how the requirements from Exhibit A and Attachment 11 should be integrated? There are many topics to be covered in the proposals, and we want to be sure that the Department's requirements are addressed completely and succinctly.	Exhibit A, Attachment I describes the requirements for each section of the Scope of Work (SOW) of the Contract. The workplans to be submitted shall describe the contractor's method for complying with the requirements of the SOW. The workplan must integrate the requirements of the SOW using the format of the work plan content (K.3.e.3, p.20). Submisssion of the Implementation Plan and Deliverables, Provision J, p.18, will be subject to CDHS approval which shall not be unreasonably withheld following the guidelines of the Readiness Review Tool (Apendix 5).
7	RFP Main, Section M.2-6, Proposal Evaluation	32	Please clarify the scoring method for both the technical and rate proposals, with examples if possible.	The Technical Proposal will be worth from 0-328 points. The Rate Proposal will also be worth 0-328 points, with the lowest rate proposal earning the maximum number of points. Other rates will earn a percentage of the maximum based on the formula in Section M.3. A proposer's final score will be calculated as follows: (TP x 70%) + (RP x 30%) = Final Score Addendum 4 will address this issue further.
			Section: Exhibits	
8	Exhibit A, Attachment 1, Section A.1.a, Contract Administration	1	The section indicates that a "written procedure for the conduct of the business of the organization, is sufficient to result in effective conduct of the organization's business." Could the Department clarify the scope of this procedure? Organizational policies and procedures relative to the entire business would be voluminous, difficult to review in entirety, and not exclusively relevant to the DMPP.	Exhibit A, Attachment 1, A.1.c requires the proposer to have organizational and administrative capabilities to perform its duties and responsibilities under the contract which include written procedures for the conduct of the business of the organization, which provides effective controls. This requirement can be met in various ways, one of which would be to provide a list of all policies and procedures that govern all aspects of its operations. Adequeate organizational and administrative capability is a requirement of DM accreditation from URAC, JACHO or NCQA.
9	Exhibit A, Attachment 1, Section A.2, Medical Director	1	Please confirm our understanding that the Medical Director should be licensed in California. Does the Medical Director need to be located in California if licensed in the state?	This will be corrected and included in a future addendum. There is no requirement that the Medical Director be located in California. The Medical Director must be licensed in California.
10	Exhibit A, Attachment 1, Section A.3, Reporting Requirements	2	In the event that the 10th calendar day falls on a weekend or holiday, when will reports be due?	Reports will be due on the first working day following the weekend or holiday.

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QUESTION #	RFP SECTION	Pg	QUESTIONS	ANSWERS
11	Exhibit A, Attachment 1, Section A.3, Reporting Requirements	2, 3	Can the Department provide examples of other reports that may be required, or parameters for estimating the level of effort for budget purposes associated with additional reporting requirements?	We anticipate minimal other reporting requirements and any that would be required would be of a similar nature to those listed in the RFP.
12	Exhibit A, Attachment 1, Section A.3, Reporting Requirements	2	Please provide additional detail for the semi-annual member status reports. a. Should these assessment reports be at the individual level, aggregated by disease state or some other category? b. Could CDHS provide information about the format of the report? c. How will the lag period for claims be taken into account?	a. + b. The content and design of these reports will be subject to CDHS approval which shall not be unreasonably withheld. However, the proposer should have a data system capable of producing both individual and aggregated reports of the DM services provided to, and the disease status of, each Member, including major events and mortality and morbidity. c. CDHS will only expect the contractor to report on claims information that is available at the time the report is due. CDHS is aware that the claims lag period will affect the completeness of reporting.
13	Exhibit A, Attachment 1, Section A.3, Reporting Requirements	3	The Annual Report is to be submitted 30 days after the close of each 12 month period. a. Does the initial period begin on contract implementation or after implementation? b. How will the lag period for claims be taken into account in the Contractor self-assessment?	a. The annual report is due 30 days after the close of each of the three 12-month operation periods. b. CDHS will only expect the contractor to report on claims information that is available at the time the report is due. CDHS is aware that the claims lag period will affect the completeness of reporting.
14	Exhibit A, Attachment 1, Section A.3, Reporting Requirements	2	Monthly reporting includes due dates and completion dates for 30 day evaluations. Can CDHS provide additional information about these evaluations, including requirements or reporting when evaluations are due and completed for individual members?	An addendum will be issued to correct Exhibit A, Attachment 1, provision A.3 to read " Identification of individual Member 60 day assessment due dates and completion dates." The minimum requirements for the 60 day assessment are listed in Exhibit A, Attachment I, provision G.1.b, p. 11. The contractor has the flexibility to include whatever information it deems pertinent to the development of the ITP, subject to and following the guidelines listed in G.3.b, p.14.
15	Exhibit A, Attachment 1, Section C.2.c, Quality Improvement System	4	The section requests a written description of "activities designed to ensure the provision of case management and coordination of services." Could the Department elaborate on this request? It seems to have different context than items (a) and (b).	The activities referred to include a description of the scope and method of the Quality Improvement program that ensures required DM services are rendered.

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QUESTION #	RFP SECTION	Pg	QUESTIONS	ANSWERS
16	Exhibit A, Attachment 1, Section D, Utilization Monitoring	6	Could the Department describe the contemplated frequency of data provided to the Contractor, as well as provide an indication of the lag time for data completeness?	Claims and eligibility data will be provided to the contractor monthly. Claims data may not include claims filed within the previous 60-90 days. Additionally, there is a sliding percentage of claims that will not yet be filed. The percentage of these unfilled claims will decrease as time passes, so that after one year, nearly 100% of claims will be filed.
17	Exhibit A, Attachment 1, Section D, Utilization Monitoring	6	How will pharmacy data be transmitted and what is the frequency and format?	Pharmacy claims data will be transmitted with other claims data using the same format. Also see Question 16.
18	Exhibit A, Attachment 1, Section D, Utilization Monitoring	7	Please provide additional information about the prior authorization process and the expectations for the Contractor to interact with this system.	The prior Authorization process is the process currently in use for Medi-cal fee-for-service beneficiaries. Additional information about the treatment authorization request (TAR) process can be found in the Medi-Cal Provider Manuals. The contractor is not expected to interface with the TAR process. The contractor will not have to use the TAR process regarding the provisions of any services it is contracted to provide.
19	Exhibit A, Attachment 1, Threshold Language	8	Will CDHS accept a phased in approach to translation of materials into the threshold languages?	The requirement for threshold languages is that written materials be available in threshold languages within 14 days upon receipt of any request , either written or oral, by a Member. CDHS expects to see a description of the process for meeting this timeline in the readiness review conducted during the implementation phase of the contract.
20	Exhibit A, Attachment 1, Section E.1.g.9, Member Services – Member Rights	9	Please provide an example of the additional information that might be requested by the Department.	For example, CDHS may determine that dispute resolution information is essential for inclusion in the Member handbook.
21	Exhibit A, Attachment 1, Annual Marketing Plan		Can you provide clarity on the expectations of what types of materials are to be included in the annual marketing plan?	There are no minimum requirements on marketing materials. CDHS must approve any and all marketing procedures, activities and methods.
22	Exhibit A, Attachment 1, Section G, Member Scope of Services	11	Please provide additional information about responsibility for assisting members to receive other services, given that the Contractor does not conduct prior authorization.	In this case, referral is not meant to imply authorization by the DMO, but rather, information about the availability of services and assistance in coordinating access to needed services.

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QUESTION #	RFP SECTION	Pg	QUESTIONS	ANSWERS
23	Exhibit A, Attachment 1, Section G, Member Scope of Services	11	The member assessment is to be conducted within 60 days of enrollment. Is that time period extended during implementation? Also, the assessment is to be updated at least annually. How does this timeframe correspond to the semi-annual reporting for member assessments?	Enrollment will not begin until the operations period begins. The Member assessment must be completed, or updated, by the DMO at least annually. The Member status report must be reported to CDHS twice each year. The Member assessment is designed to confirm eligibility and assess disease state. The Member status report will include other information, including but not limited to, DM services provided, major events, and morbidity and mortality.
24	Exhibit A, Attachment 1, Section G.1.b	11	Member assessments are to be conducted within 60 days. Please indicate if this assessment is the same process as the evaluation described in Section A.3.4, which references member 30 day evaluations.	The assessment is the same as the evaluation and the 30-day reference is incorrect. The assessment must be completed within 60 days of enrollment. A future addendum will correct this.
25	Exhibit A, Attachment 1, Assessment	11	Please clarify if assessment information can be obtained through a face-to-face visit as long as no other clinical medical services are provided during that visit.	Yes.
26	Exhibit A, Attachment 1, Section G, Member Scope of Services	12	When does the enrollment timeframe begin, when the Contractor receives the monthly list? How is this timing defined for operations and implementation, that is, does the Contractor have an additional 60 days during implementation for enrollment activities?	An addendum will be issued to remove the reference to an initial time extension and will be replaced with the following language: "The size of the initial enrollment list and any additional time allowed for the initial enrollment is subject to CDHS approval which shall not be unreasonably withheld. In addition, enrollment may only take place during the Operations Period."
27	Exhibit A, Attachment 1, Section G .2, Approval Process	12-13	CDHS approval timeline is 60 days. Does this imply that CDHS will approve in 60 days or less?	Additional information is needed in order to answer this question. There is an explanation of a CDHS Approval Process described in Exhibit E, provision 36, p.19.

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QUESTION #	RFP SECTION	Pg	QUESTIONS	ANSWERS
28	Exhibit A, Attachment 1, Section G.2, Enrollment/ Disenrollment	12	a. How many members will be included on the monthly list? b. Will the additional member lists be generated during the month for additional enrollment if needed? c. Does the Department have a target for monthly enrollments? d. How will members be divided into monthly enrollment listings? e. Do the population counts take into account co-morbid conditions? f. If members have more than one target condition, what criteria are used to assign them to specific disease groupings?	a. CDHS has identified approximately 19,000 potential eligible members. The number included on the monthly list will be subject to CDHS approval which shall not be unreasonably withheld. b. The process for generating and providing monthly enrollment lists will be finalized by CDHS. c. CDHS does not have a target for monthly enrollment. CDHS wishes to maximize enrollment for all disease categories while maintaining the integrity of the enrollment process. d. The process for generating and providing monthly enrollment lists will be finalized by CDHS. e. No f. See methodology in the data library.
29	Exhibit A, Attachment 1, Scope of Services, Provision G	12	Provides eligibility criteria and so does Appendix 2; however, Appendix 2 appears to have less criteria listed. Which list should be used?	The Scope of Services Provision G provides eligibility criteria. Appendix Two provides further detail regarding the aid codes and ICD-9 codes used to identify potential members.
30	Exhibit A, Attachment 1, Enrollment/ Program Evaluation	12	If the contractor is not able to enroll 250 eligibles in each disease category in each county, what happens? Consider, for example, that there are only 234 eligible CAD members in Alameda county according to the 2004 data.	An addendum will be issued to include the following language: 'The minimum enrollment requirements will be subject to availability of sufficient numbers of potential Members in the pilot areas and will be subject to CDHS approval which shall not be unreasonably withheld."
31	Exhibit A, Attachment 1, Enrollment/ Program Evaluation	12	According to the RFP and unofficial Q & A, a minimum of 250 persons per disease stated per county is required; however, according to the numbers provided in the Data Library, persons diagnosed with CAD in Alameda county do not total 250. How will this be handled (what will the effect be)?	See answer to Question 30.
32	Exhibit A - Att. 1, Eligibility Data	12	Will the State provide monthly eligibility refreshes or updates, in addition to the monthly list of potential Members for the DMPP program, to ensure the vendor is managing only beneficiaries who are eligible for Medicaid services?	Yes.
33	Exhibit A, Attachment 1, Enrollment	12	When will the initial list of members be provided to the Contractor?	The timing of the release of the initial eligibility list is subject to CDHS approval which shall not be unreasonably withheld, but will not commence prior to completion of the readiness review.

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QUESTION #	RFP SECTION	Pg	QUESTIONS	ANSWERS
34	Exhibit A, Attachment 1, Enrollment	12	What information will be provided on the monthly list of potential Members?	The type of information is subject to CDHS approval which shall not be unreasonably withheld, but will include at a minimum, name, contact information, language and qualifying disease.
35	Exhibit A, Attachment 1, Enrollment	12	What is CDHS' historical experience with accuracy/completeness of member phone number data?	The data is unavailable.
36	Exhibit A, Attachment 1, Enrollment	12	Is the 7 percent error rate (contact information) for the general population or this specific population? If for the general population, does CDHS have it for this specific population?	Information previously provided regarding the error rate is incorrect. Error rate data is unavailable.
37	Exhibit A, Attachment 1, Enrollment	12	Regarding the "initial contact" date from which a member has 30 days to opt-out. How is initial contact defined? Must the contact be live, or can it be by mail?	The opt-out period begins with the postmark on the letter of DMPP eligibility notification. An addendum will be issued for this process.
38	Exhibit A, Attachment 1, Enrollment	12	Is the onset of "enrolled" status for billing purposes only a function of the first month following the 30-day opt-out period after the date of the initial contact? What if a member agrees to participate on the initial contact, and is assessed and has an ITP developed before the 30-day opt-out period - are they still not "enrolled"?	A member may be enrolled prior to the 30-day opt-out period if the member contacts the DMO and elects to participate in the program, but the enrollment will not start until the first of the month following the members notification of participation.
39	Exhibit A, Attachment 1, Enrollment	12	Regarding the statement "during the implementation phase, the Contractor shall have an additional two months to complete each phase of the enrollment and initial services", from what point will the two months be measured? Does this imply that if the contractor has not completed all the phases of enrollment and initial services for a particular member before the end of the implementation phase, then those efforts should cease and the member disenrolled?	An addendum will be issued to replace this section. Enrollment will only be allowed during the Operations Period of the contract. Also see Question 26.
40	Exhibit A - Att. 1, Enrollment	12	Will CDHS provide the DMO with 100% of the eligibles in the first list? If not, how many members will they refer to us?	An addendum will be issued which contains the following language: "The size of the initial enrollment list and any additional time allowed for the initial enrollment is subject to CDHS approval which shall not be unreasonably withheld. In addition, enrollment may only take place during the Operations Period." Also see Question 26.
41	Exhibit A, Attachment 1, Section G, Member Scope of Services, Disease Management	14	Does medication management refer to only medication related to the six disease states that we are managing or all medications for the enrolled members?	According to the holistic disease management approach, the DMO's Individual Treatment Plan should address all aspects of the Members health that affect their chronic condition and overall health status, including management of all medications, not just medications associated with DM eligible disease(s).

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QUESTION #	RFP SECTION	Pg	QUESTIONS	ANSWERS
42	Exhibit A, Attachment 1, ITP	14	RFP states the ITP is to be completed and in place within 90 days of membership. Does this requirement refer to within 90 days of enrollment into a disease management program?	Yes.
43	Exhibit A - Att. 1, ITP	14	RFP states the ITP is to be completed and in place within 90 days of membership. Does this requirement refer to within 90 days of enrollment into a disease management program?	Yes, the ITP must be completed and in place within 90 days of membership into the DMPP.
44	Exhibit A, Attachment 1, Medication Management		Can CDHS clarify the requirements within the medication management section, such as, frequency of monitoring, medication profiling, etc.?	The requirement is for the contractor to have policies and procedures (P&Ps) for addressing medication management. The adequacy of the P&Ps will be determined by the Contract Manager on a case-by-case basis. See Question 29.
45	Exhibit A, Attachment 1, Section G, Member Scope of Services, Disease Management	14, 15	The Individual Treatment Plan must include provisions for semi-annual review and update. On page 11 of the Exhibit, assessments are to be no less than annually. Can CDHS provide clarification of these timeframes?	The Member assessment (p.11) is designed to confirm eligibility and assess disease state and is required to be done at least annually. The ITP is the plan of care based in part on the assessment of the disease state as well as clinical and psychosocial data and must be done at least semi-annually or more often if required by the condition.
46	Exhibit A, Attachment 1, Section G, Member Scope of Services, Disease Management	15	Staffing for the Health Advice Line is to be a registered nurse or other health care professional. a. Do these staff members have to be licensed in California? b. Do they have to be located in California?	There is no requirement that the Health Advice Line staff be located in California. The Health Advice Line staff must be licensed in California per Business and Profession Code 4999.2 as referenced in the RFP.
47	Exhibit A, Attachment 1, Section G, Member Scope of Services, Disease Management	15	Is support, clerical, and non-clinical in nature staff required to have a medical/professional license?	No, persons not working in a medical professional capacity are not required to be licensed/certified.
48	Exhibit A, Attachment 1, Utilization Data	15	The RFP requires that the nurse advice line provide relevant utilization data. In this case, does utilization data refer to summary reporting of the nurse advice line usage?	Summary reporting of the advice line to CDHS is required in Exhibit A, Attachment I, provision A. Relevant Utilization data provided to persons utilizing the advice line could, for example, include paid claims data and provider visits, which is data that may be useful in assisting a member with their question and/or ITP.

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QUESTION #	RFP SECTION	Pg	QUESTIONS	ANSWERS
49	Exhibit A, Attachment 1, Behavioral Health Expertise	15	The contractor must employ the services of a licensed psychiatrist, psychologist, or licensed/certified mental health specialists. Would the State consider Registered Nurses with behavioral health specialties as meeting this requirement?	A licensed psychiatrist or psychologist or a licensed/certified mental health specialist, as needed, must be available for participation in the development of the Individual Treatment Plan. Registered Nurses with behavioral health specialties do not meet this minimum requirement.
50	Exhibit A, Attachment 1, Behavioral Health Expertise	15	What are the availability requirements for the behavioral health specialist?	The behavioral health specialist must be available as needed (Exhibit A, Attachment 1, provision G, p. 15).
51	Exhibit A, Attachment 1, Threshold Language	16	Will CDHS provide primary language in the eligibility data for the threshold languages?	Yes, as listed in Medi-Cal Eligibility Data Set (MEDS).
52	Exhibit A, Attachment 1, Members Education	16	Contractor must maintain documentation that demonstrates effective implementation of the health education requirements. Can CDHS clarify what is to be included in the documentation?	There are various forms of documentation that would satisfy the effective implementation of the health education requirements such as a QI report, patient satisfaction survey, policies and procedures, and the like. Compliance with this requirement will be determined by the Contract Manager on a case-by-case basis.
53	Exhibit A, Attachment 1, Section I, Provider Services	17	Does CDHS have an estimated number of provider trainings in mind?	No.
54	Exhibit A, Attachment 1, Section J, Implementation/ Operations	18	This section references the submission of a workplan for each county. How do these workplans relate to the workplan that is submitted as part of the proposal, which references all activities to be completed during the project?	County specific workplans are the deliverables defined by the Readiness Review Proceess, which is to be completed during the implementation phase of the contract. The details of the Readiness Review Process will be provided upon contract award. An addendum will be issued to clarify the workplans in Exhibit A, Attachment 1, Provision J.
55	Exhibit A, Attachment 1, Section J, Implementation/ Operations	18	The work plan required for the technical proposal is not county based; however, the work plan required to be submitted 15 days after the contract is awarded is county based? Is that what we want? Is there possibility of combining these two?	See answer to Question 54.

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QUESTION #	RFP SECTION	Pg	QUESTIONS	ANSWERS
56	Exhibit A, Attachment 1, Implementation plan	18	Where should we respond to the Implementation Plan and Deliverables section of Exhibit A, Attachment 1? It seems that this should this be another Work Plan, as required by Section K.3.e -- is this correct?	Only the successful bidder is required to submit this document.
57	Exhibit A, Attachment 1, Section J		Does this provision require a work plan?	See answer to Question 56.
58	Exhibit A, Attachment 1, Section J, Implementation Plan and Deliverables	18	The implementation timeframe is four months after the effective date of the contract. How will reporting of outcomes as required for Quality Improvement be affected by this timeframe?	Timeframes for reporting of outcomes as required by the quality improvement plan shall begin on the first day of the operations period, which begins at the end of the four-month implementation period.
59	Exhibit A, Attachment 1, Implementation Period	18	Given the use of the phrase "approximately 4 months..": a. If the Contractor requires less than 4 months for the implementation period, will CDHS allow the Operational period to start early? b. If so, will the total Operational period be extended beyond 36 months, or will it just shift forward? c. If for any reason the Implementation period should be delayed beyond 4 months, will the Operational period be commensurately shortened, or will the agreement term be extended to allow a full 36 months of Operational period?	a. CDHS in its sole discretion may allow the operational phase to start early. b. If the Implementation phase ends early, the operations period will remain 36 months. c. CDHS has the exclusive option to extend the contract per Exhibit E, provision 19.
60	Exhibit B, Budget Detail and Payment Provisions, Budgetary Contingency Clause	1	a. Will there be a notice period for termination or reduction if conducted as allowed by this clause? b. Does this clause incorporate the 90 day turnover period?	a. There will be a 30-day notice. b. Yes.
61	Exhibit B, Budget Detail and Payment Provisions	2	Please verify that the three year base contract may not exceed $12 million.	The three-year base contract (operation period) may not exceed 12 million.

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QUESTION #	RFP SECTION	Pg	QUESTIONS	ANSWERS
62	Exhibit B, Budget Detail and Payment Provisions, 6	2	An amount equal to 10% may be withheld from invoices for ongoing activities. Can CDHS provide examples of these activities for clarification and budgeting purposes?	A 10 percent withhold per invoice will be made per Public Contract Code requirements. The withhold will be released at the end of each operational year subject to satisfactory completion and delivery of all reporting requirements for the year. An addendum will be issued to reflect the change noted above.
63	Exhibit B, Budget Detail and Payment Provisions, 6	2	When will the payment withholds be released (i.e. end of contract, reporting period, fiscal year, etc)?	See answer to Question 62.
64	Exhibit B, Budget Detail and Payment Provisions		When calculating the rate, is it the number of enrolled members or eligible members (PMPM)?	The contractor will receive a case management fee for enrolled members only.
65	Exhibit B, Attachment 1, Risk Terms	1	Please elaborate whether the Contractor is at risk for the entire population, or just for members enrolled in the program.	The risk reconciliation will be based on total medical expenditures for the eligible population as compared to a control group, however the contractor's risk shall not exceed the total of their case management fees.
66	Exhibit B, Attachment 1,	1	Regarding the risk terms listed in Exhibit B, Attachment 1, if CDHS is going to "control" enrollment, is the Contractor at risk for just the enrolled members or the entire population?	Reference Question 65
67	Exhibit B, Attachment 1, Commencement of fees per member	1	Given that a member is "enrolled" the first of the month after the 30-day opt-out period and that the payment period commences the first day of the month following the month of enrollment, please verify or correct the following example: Member initially contacted 9/5/06; opt-out period ends 10/5/06; member didn't opt-out, so member "enrolled" 11/1/06; member billing commences 12/1/06 (first day of following month).	Yes, this is correct.
68	Exhibit B, Attachment 1, Special Payment Provisions, Recovery of Case Management Fees.	2	How will CDHS handle errors in identification made after the Contractor has conducted appropriate Disease Management activities?	The contract manager will work with the contractor on a case by case basis to determine whether CDHS will pay for services rendered to an ineligible beneficiary.
69	Exhibit B, Attachment 1, Guarantee	3	Over which period of time will the guarantee be measured? Only during the "operational" period? Or over the term of the entire contract (43 months)?	The guarantee will be calculated based on the 36 month operational period and the 3 month phase-out period.
70	Exhibit B, Attachment 1, Guarantee	3	Will the Contractor have the opportunity to review and approve the propensity matching methodology and its resulting application?	The Contractor will have the opportunity to review and provide input regarding the statiscal matching methodology.

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71	Exhibit B, Attachment 1, Guarantee	3	Will the Contractor be expected to fund the third party evaluator's analysis?	No. Funding for the third-party evaluation will be provided outside of this contract.
72	Exhibit B, Attachment 1, Guarantee	3	Will the contractor be provided interim data or reports sufficient that the contractor can evaluate the program's performance on an ongoing basis during program operations? When would such data/reports be first provided and with what frequency?	It is the responsibility of the Contractor to operate a quality improvement program to assess and improve the program's performance. It is CDHS' intention to issue quarterly report(s) beginning within the first six (6) months of the operation period.
73	Exhibit B, Attachment 1, Guarantee	3	Will there be a RFP for the third-party evaluator? What is the approach being used to obtain the services of the third-party evaluator?	The third-party evaluator will be handled through a different contract.
74	Exhibit B, Attachment 1, Guarantee	3	At what point after the end of the performance period will the final analysis to determine guarantee performance be accomplished?	The final analysis is estimated to be completed within six (6) to twelve (12) months following the end of the phase out period.
75	Exhibit B, Attachment 1, Guarantee	3	Please clarify the proportional payback with another example, on page 3 it is defined as the same proportion that the cost neutrality target is missed, yet the example on page 5 shows a target of $500, a miss of $40 (which is an 8% of the target, yet the example shows a 100% payback).	Whatever dollar amount the contractor misses the target by, the contractor must refund an equivalent dollar amount up to 100% of their case management fees. If the target for total medical expenses and contractor fees is $1,000,000 and the actual combined cost was $1,000,027, then the contractor is responsible to refund $27.

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QUESTION #	RFP SECTION	Pg	QUESTIONS	ANSWERS
76	Exhibit B, Attachment 1, Section 8, Special Payment Provisions	3	This section provides an extensive discussion of the risk-bearing requirements for the DMPP Contractor, and we have several questions about the methodology. a. Will comparison groups be created at the disease specific level? Will the comparison groups be matched to the intervention group for disease state, co morbidities, and cultural characteristics? b. The section specifies that costs for DMPP eligible members (not only those enrolled in the DMPP) will be used to calculate the cost-neutrality. In Section G, however, one function of the member assessment is to validate the medical eligibility of the member to participate in the DMPP. Will individuals determined to be not medically eligible be eliminated from the cost neutrality calculation? c. In the cost neutrality calculation, costs are compiled based on care provided to the comparison group and any differences in fee structure or patterns of care will impact the cost calculation. Is the provider fee structure universal across comparison group(s) and the intervention counties? Does it take into account individual provider practice patterns and referral sources? When comparing costs, are disease specific costs compared, or total costs?	a. Comparison groups will be created at the disease specific level, but the guarantee reconciliation will be done for the aggregated eligible population. The comparison group will be matched to the intervention group for disease state, co morbidities, and demographics. b. No, individuals determined to be not medically eligible stay in the cost neutrality calculation because there is no method from removing them from the control group. c. If the provider fee structure is disparate between the comparison groups and the intervention counties, the comparison will be adjusted to account for the disparity and the methodology used will be subject to CDHS approbal which shall not unreasonably withheld. The matching process or the reconciliation calculation may take into account provider practice patterns or referral sources. Total costs (total medical expenses, including the case manageement for the intervention group), not disease-specific costs, will be compared.
77	Exhibit B, Attachment 1, Savings Guarantee	4	Will the State consider adding a stop loss amount for outliers from both the pool of the DMPP Eligible participants as well as the matched control group? A single outlier will prevent an equitable comparison of DMPP participants to FFS beneficiaries without DM services.	The state will not consider adding a stop loss for outliers.
78	Exhibit E	19	The Exhibit indicates a 60 day timeframe for approval of materials. a. What is the process for receiving written approval from CDHS? b. During implementation, how will the approval process be conducted?	All operational issues are subject to CDHS approval which shall not unreasonably withheld.
			Section: Appendices	
79	Appendix 1, Glossary	1	Does CDHS' definition of Case Management refer only to catastrophic case management services?	No. An addendum will be issued to remove the reference to "intensive intervention" in the definition of case management and replace it with the term "any intervention." Also, the addendum will delete ". . . and it is distinguished from disease management by its intensity and focus on any disease(s) conditions the member has." in its entirety.

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QUESTION #	RFP SECTION	Pg	QUESTIONS	ANSWERS
80	Appendix 2, Eligibility Criteria Chart	1	The Coronary Artery Disease (CAD) DM program includes such diagnosis categories as angina (413) and its variants. The Atherosclerotic Disease Syndrome also includes these same diagnoses as "included" in the DM population. Is it the intent that these patients are eligible for two separate programs, or, if one program addresses their issues, would a single atherosclerotic program be appropriate?	If the Member has one of the DMPP eligible diseases, then they are eligible for the DMPP. If they qualify as having two of the eligible diseases, they will be assigned to a primary disease category. But, it is expected that co morbidities will be addressed through the Individual Treatment Plan, regardless of the Member's primary category.
			Section: Data Library	
81	Data Library		Regarding the Report/Table on Paid Claims of Eligibles, in the "Net Payments" Column, to what does the "Mean" refer.	The mean represents the mean net payment per claim in the associated row.
82	Data Library		Are partnership arrangements allowed between DM venders in response to this RFP?	The contract will be awarded to one DMO that will be allowed to subcontract, subject to requirements in the RFP and awarded contract.
83	Data Library		In the RFP you state on page 10 that "a Data Library will be established on March 15, 2006. The Data Library will be in an electronic format in its entirety". I have accessed the online information and have found: Report tables for paid claims—this is summary data for the two counties Data file specifications including data layout and data dictionary I did not find raw claims data, which would be helpful in responding to the RFP. Is this available in the electronic Data file? If not will it/can it be available?	Record level data will not be provided. CDHS determined that the aggregated data provided is all that is required to complete the bidding process. CDHS consulted with several sources including, but not limited to, program experts, other State Medicaid DM programs, in-house data experts, to determine the sufficient amount of information necessary to be provided in the Data Library.
84	Data Library		In the RFP there is no reference to behavioral health conditions. In the paid claims information provided in the Data Library there is also no information for behavioral health conditions such as depression, substance abuse and anxiety. Following are two related questions: a. Are behavioral health conditions "carved out" to a behavioral health vendor? b. Will individuals with persistent and significant behavioral conditions or other major behavioral health conditions be included in the pilot program population?	Behavioral health conditions are not carved out of this program. It is expected that behavioral health conditions will be addressed as a co-morbidity. The DMO is not providing direct medical or psychological services, but will be expected to coordinate behavioral services in conjunction with other chronic disease services, according to the holistic approach to disease management.

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QUESTION #	RFP SECTION	Pg	QUESTIONS	ANSWERS
85	Data Library		Many people with renal disease have pre existing conditions such as Diabetes, Coronary Artery Disease or Chronic Heart Failure. Does the pilot program include beneficiaries who currently have ESRD or who develop ESRD as a result of one of the listed diseases, during the contract period?	The pilot program does not include beneficiaries who currently have ESRD, and Members who develop ESRD will be disenrolled only at their request.
86	Data Library		Are laboratory results available for the following codes: 82565 Serum Creatinine 82575 Creatinine Clearence	Lab values are not available for the procurement process. The DMO may gather lab values through chart reviews during the operation phase of the contract.
87	Data Library		Would the State please define "beneficiary" as described in the data tables? For example, are beneficiaries program eligible or are program and actual services users?	Beneficiaries, as described in the data tables, include those who meet disease and exclusionary criteria for the program in the pilot areas. For more information, see the methodology document in the data library.
88	Data Library		Would the State please provide estimated annual enrollment growth projection and service utilization trends for the DM pilot program, beginning with 2004, for the target implementation years (August 1, 2006 through February 28, 2010)?	The Department believes it has supplied sufficient information.
89	Data Library		Would the State please provide the annual average eligible months by disease state for the DM beneficiary statistics summarized for SFY 2004?	The Department believes it has supplied sufficient information.
90	Data Library		Can the State provide any additional data on the co-morbidities of the individuals eligible for the program, specifically those with behavioral health diagnoses that maybe primary or secondary?	The Department believes it has supplied sufficient information. Note that the successful bidder will be provided claims data on a monthly basis which will include this information.
91	Data Library		How many eligible members constitute the entire DMPP eligible population in the pilot areas?	According to initial calculation, there are 11,281 DMPP eligible beneficiaries in the Los Angeles County pilot areas and 7,686 DMPP eligible beneficiaries in the Alameda County pilot area. CDHS will run monthly lists to capture newly eligible beneficiaries and provide this information to the Contractor.
92	Data Library		Does the eligible population count identified in the RFP and unofficial Q & A exclude persons diagnosed with HIV/AIDs?	Persons with HIV/AIDs were not included in the eligible population count.

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QUESTION #	RFP SECTION	Pg	QUESTIONS	ANSWERS
			Section: General Questions	
93	General		Are partnership arrangements allowed between DM venders in response to this RFP?	The contract will be awarded to one DMO that will be allowed to subcontract., subject to the requirements in the RFP and the awarded contract.
94	General		If a member does not elect to opt-out after the initial thirty day period, are they then "locked in" to the program for a given period? How long is that period?	The Member may disenroll at any time without cause.
95	General		Pending the success of the program, would the State consider expanding the program the funding and service area of the DM program before the end of the planned pilot program?	The state in its sole discretion may consider expanding the program during the pilot period, but there are no plans to do so at this time.
96	General		Can the contractor enroll members during the operational period as well as the implementation period?	The contractor may enroll members only in the Operational Period. The contractor may not enroll members during the Implementation Period. Also see Questions 26 and 39.
97	General		Will the State be providing a list of eligible members throughout the Operational Period as needed to maintain the minimum 250 members per disease state per county per year requirement?	Yes. An updated eligibility list will be sent to the contractor on a monthly basis. Also see Question 30.
98	General		Will the State provide the DMO with claims data to identify potential eligible members, in addition to the list of eligible members?	No. Claims data will only be provided on enrolled members.
99	General		If a person is diagnosed with HIV/AIDs, while receiving DMPP services, can they continue to receive services from the DMPP?	No.
100	General		What reports, systems, database, etc is owned by the State or retained by the Contractor?	See Exhibit D(F) for details of data and intellectual property rights ownership information.
101	General		Are persons receiving services in Regional Centers eligible for the DMPP, excluding those participating in a waiver?	Persons not in a waiver or otherwise excluded (i.e. comparable case management services) could be eligible to participate in the DMPP, including those in Regional Centers.

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QUESTION #	RFP SECTION	Pg	QUESTIONS	ANSWERS
102	General		"If a beneficiary has more that one disease state under the study design, they classified them under the disease state where there were the most paid claims. Then they added all the other disease state claims to that disease state. So, if someone had $1500 in CAD claims and $500 in diabetes claims, they classified them under CAD and said the net claims for that disease were $2000." a. What if the dollar amount changes over time and, in your example, diabetes becomes prime. Will the person be reported from the state (and in the downstream data transmission) as belonging to a different disease bucket than before? This may be an issue for Reporting and Reconciliation with regarding to reporting on disease state. b. Also, from an application perspective, we will now have to change the primary disease to be consistent with the participation's disease ID movement. And is it safe to say that when this occurs, the person's ID (from the state) will not change? Are there any co morbidity reporting requirements?	a. and b. Once classified, the Member will not change disease buckets. There are no co morbidity reporting requirements, but information on co morbidities should be appropriately incorporated in documentation of the Member assessment and/or Individual Treatment Plan.
103	General		Is there a follow-up End Stage Renal Pilot Program scheduled?	Not at this time.
104	General		If a person is receiving services through the DMPP, and are diagnosed with HIV/AIDS, can they remain in the DMPP with HIV/AIDs being treated as co morbidity to the DMPP qualifying disease?	Persons who develop HIV/AIDS will be excluded from the program.
105	General		If a person is diagnosed with HIV/AIDs, while receiving DMPP services, can they continue to receive services from the DMPP?	Persons who develop HIV/AIDS will be excluded from the program.
106	General		What is the FFP rate? If 50/50, how should a Quality Improvement Organization (QIO) bring to the attention of CDHS the conversations currently being held with CMS regarding QIOs receiving a 75/25 FFP for certain responsibilities in contracts?	Any discussions with CMS should be brought to the attention of the Department, but should be done separate to this Procurement.